POLICYHOLDERCounty of Fairfax, Virginia

TL-004038(BME) PM-615332f(Enrollment Form)/AR-0011-14136(9/07) POLICY NUMBER VDT-001017

CIGNA Group Insurance
Life · Accident · Disability

Long-Term Disability Enrollment Form

Name	First		M. I.	Sex: □ Male □ Female
Date of Birth		En	nployee ID_	
Address	City	State	Zip Code	ome Phone ()
Date Hired	Title or Occupation			Annual Salary \$

Please check the appropriate box.				
☐ I accept the optional LTD insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.				
☐ I have been offered optional LTD insurance and decline to purchase it at this time. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.				
Late entrants must complete an Evidence of Insurability Form. Coverage for late entrants is subject to the Insurance Company's approval.				
If you are not in active service on the date your coverage would otherwise take effect, you will be covered on the date you return to active service.				
Pre-Existing Condition Limitation: A pre-existing condition is any injury or illness for which you have consulted a physician (or for which a reasonable person would have consulted a physician), received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 months after the effective date of your coverage.				
Signature of Applicant				Date
				N.K.

A copy of the plan certificate can be found on infoweb or the Department of Human Resources.

Return to Employee Benefits Division, Department of Human Resources.